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In the Supreme Court of the United States

PACIFICARE OF CALIFORNIA, INC.,
PACIFICARE HEALTH SYSTEMS, INC. AND
GREATER NEWPORT PHYSICIANS, INC.

Petitioners,

v.

BARBARA MCCALL
Individually and as Trustee, etc.,

Respondent.

On Petition for a Writ of Certiorari to the Supreme Court of California

BRIEF OF THE AMERICAN ASSOCIATION OF HEALTH PLANS, THE AMERICAN BENEFITS COUNCIL, AND THE HEALTH INSURANCE ASSOCIATION OF AMERICA AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

KENNETH S. GELLER
Counsel of Record
MIRIAM R. NEMETZ
Mayer, Brown & Platt
1909 K Street, N.W.
Washington, D.C. 20006
(202) 263-3000

Counsel for *Amici Curiae*
Additional Counsel Listed On Inside Cover

24 pp

LOUIS SACCOCCIO
General Counsel
American Association of Health Plans
1129 20th Street, N.W.
Suite 600
Washington, D.C. 20036
(202) 778-3200

LYNN D. DUDLEY
Vice President and Senior Counsel
American Benefits Council
1212 New York Avenue, N.W.
Suite 1250
Washington, D.C. 20005
(202) 289-6700

JEFFREY L. GABARDI
Legislative Director and Deputy General Counsel
Health Insurance Association of America
1201 F Street, N.W.
Suite 500
Washington, D.C. 20004
(202) 824-1621

Additional Counsel for *Amici Curiae*

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BRIEF OF THE AMERICAN ASSOCIATION OF HEALTH PLANS, THE AMERICAN BENEFITS COUNCIL, AND THE HEALTH INSURANCE ASSOCIATION OF AMERICA AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

INTEREST OF THE *AMICI CURIAE*[1]

The American Association of Health Plans, Inc. (AAHP) is the national association for the managed health care community. Its membership includes health maintenance organizations (HMOs), preferred provider organizations (PPOs), third-party health benefit administrators, health care utilization review organizations, prepaid limited health service plans, and other integrated health care delivery systems. AAHP represents more than 1,000 managed health care organizations serving nearly 150 million Americans. AAHP's mission is to advance health care quality and affordability through leadership in the health care community, advocacy, and the provision of services to member health plans. A significant number of AAHP member health plans participate in the Medicare program and, therefore, are directly affected by the issue presented by this case.

The American Benefits Council (the "Council") is a broad-based, non-profit trade association founded in 1967 to protect and foster the growth of this nation's privately sponsored employee benefit plans. The Council's members include both small and large employer-sponsors of employee benefit plans, including many Fortune 500 companies. Its

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[1] The parties have consented to the filing of this brief; the written consents have been filed with the Clerk. This brief was not authored in whole or in part by counsel for a party, and no person or entity, other than the *amici curiae*, their members, and their counsel made a monetary contribution to the preparation and submission of this brief.

members also include many employee benefit plan support organizations, such as actuarial and consulting firms, insurers, banks, investment firms and other professional benefit organizations. Collectively, the Council's approximately 250 members sponsor and administer plans covering more than 100 million plan participants and beneficiaries.

The Health Insurance Association of America (HIAA) is one of the largest associations of health insurance companies in the world. HIAA is an advocate for the private, market-based health insurance system. Its more than 300 members provide medical expense and supplemental insurance, as well as long-term care insurance and disability income protection to more than 123 million Americans. HIAA develops and advocates federal and state policies that build upon our health care system's quality, affordability, accessibility and responsiveness.

INTRODUCTION AND SUMMARY OF ARGUMENT

Despite the long-settled rule that Medicare beneficiaries may not raise claims "arising under" the Medicare Act without first exhausting their administrative remedies (see 42 U.S.C. §§ 405(g),(h)), the California Supreme Court has allowed a Medicare beneficiary enrolled in an HMO to bypass administrative review procedures and file state-law tort claims predicated on the HMO's denial of benefits. The court's decision – which directly affects the large population of Medicare beneficiaries residing in California – will undermine Medicare's carefully structured administrative review process and impose unwarranted costs on the Medicare system. Moreover, by threatening participating health plans with expansive and unpredictable tort liability for their coverage decisions, the decision below will inhibit the development of alternatives to the traditional fee-for-service Medicare program.

In recent years, Congress has made efforts to expand participation by Medicare beneficiaries in a variety of health care plans, including HMOs, offered by private entities under contract with the federal government. These plans provide Medicare beneficiaries with more options for their health care coverage – and, in many cases, additional benefits – while saving the government money. At the same time, Congress and the Secretary of Health and Human Services have strengthened the already extensive internal and external appeal rights of Medicare beneficiaries participating in Medicare HMOs and other non-traditional health plans. The government has recognized that the prompt resolution of disputes over benefits is particularly important in the managed care arena, where benefit decisions are sometimes made *before* treatment is provided. The administrative review procedures now in place are designed to promote uniform and speedy resolution of claims for benefits and minimize costs while ensuring that beneficiaries suffer no harm from the improper denial of medical services.

The decision below will allow Medicare beneficiaries to ignore the administrative review process and, instead, to seek damages from the health plans that denied their requests for services. This will harm the beneficiaries themselves, who by failing to appeal administratively will give up their best chance of obtaining the services they desire. It will harm private health plans participating in Medicare, by subjecting them to exploding litigation costs and inconsistent standards of conduct. And it will harm the Medicare program, by increasing costs and discouraging private organizations from offering Medicare beneficiaries the variety of health care options that Congress wished to provide to them. Because the potential effects of the California Supreme Court's decision are so significant, review by this Court plainly is warranted.

ARGUMENT

A. Alternatives To Traditional Fee-for-Service Coverage Are An Increasingly Important Part Of Medicare.

Under Medicare's traditional fee-for-service program, the federal government makes a payment for each individual Medicare-covered service provided to a beneficiary. In 1982, Medicare's risk-contract program was created, allowing private entities, mostly HMOs, to contract with the Health Care Financing Administration (HCFA) to provide services to Medicare enrollees.[2] See 42 U.S.C. § 1395mm. Under this program, the government pays the HMO a preset monthly payment for each enrollee. See *id.* § 1395mm(a)(5)(A)-(B).[3] In exchange, the HMO agrees to provide each enrollee with coverage of all Medicare-covered items and services, as well as additional benefits under specified circumstances. See *id.* § 1395mm(b)(2).

Medicare managed care programs offer advantages to both beneficiaries and the government. Most plans provide benefits not covered by the Medicare program, such as routine vision care, dental care, and prescription drugs, at little or no additional cost to the beneficiary. Statement of Bruce C. Vladeck, Ph.D., Administrator, HCFA, before the Subcommittee on Health of the House Committee on Ways and Means (March 6, 1997) <http://www.house.gov/wys_means/-health/105cong/3-6-97/3-6-vlad.htm.> Many Medicare HMOs also offer preventive care services, such as routine screening for chronic illnesses, functional assessments, and education for self-care. See P. Fox & T. Fama, *Managed*

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[2] In June 2001, HCFA changed its name to the "Center for Medicare and Medicaid Services," but this amicus brief, like the petition, refers to this entity as HCFA.

[3] Some HMOs are reimbursed based on actual usage of health services by their members. See 42 U.S.C. § 1395mm(h).

Care and the Elderly: Performance and Potential, 20 GENERATIONS 31, 33 (1996). Beneficiaries in Medicare managed care programs also generally incur fewer out-of-pocket expenses than they would pay under the fee-for-service program. See J. Baker, *Medicare HMOs and the Medicare+Choice Program*, 27 PLI/NY 109, 114 (1998). At the same time, the government saves money when beneficiaries enroll in managed care because the fixed fee it pays for each enrollee is lower, on average, than the amount it would spend to cover services provided under the traditional fee-for-service arrangement. *Id.* at 117. Even with those cost savings, "[m]ost studies have found that the quality of care received by Medicare beneficiaries in HMOs is comparable to or better than that received in [fee-for-service] settings." J. Oberlander, *Managed Care and Medicare Reform*, 22 J. HEALTH POL'Y & L. 595, 610 (1997).

In the last decade, managed care has became a far more significant part of the Medicare landscape. In 1990, only about 3% of Medicare beneficiaries were enrolled in a managed care program. Congressional Research Service, MEDICARE+CHOICE (updated Jan. 10, 2001) ("CRS Report") at 8. By 2000, about 16% of beneficiaries had enrolled in a managed care plan. *Id.* at 4. Nearly one-quarter of all Medicare beneficiaries enrolled in managed care reside in California. *Id.* at 15.

On August 5, 1997, as part of the Balanced Budget Act of 1997 (Pub. L. No. 105-33 § 1851, 111 Stat. 251), Congress created the Medicare+Choice (M+C) Program in an effort to provide additional opportunities for beneficiaries to move from traditional fee-for-service coverage to alternative health plans. The M+C Program not only allows beneficiaries to participate in traditional managed care plans such as HMOs, but also aims to give them access to a broad array of plans

comparable to those available through private insurance.[4] These include Provider Sponsored Organizations (which are a type of HMO established by a provider such as a hospital), Preferred Provider Organizations (which are groups of providers that contract with a health plan or an insurer to offer their services on a fee-for-service basis), Medical Savings Accounts (under which beneficiaries purchase a private high deductible catastrophic health insurance policy and establish a tax-free savings account for paying out-of-pocket expenses), and Private Fee-for-Service Plans (under which beneficiaries purchase health insurance policies for which HCFA will contribute a flat-fee payment). See generally J. Baker & S. Levin, *Medicare: Nuts and Bolts*, 75 PLI/NY 225, 238-239 (2000). The Congressional Budget Office predicts that, by 2010, about 31% of all Medicare beneficiaries – or about 14 million enrollees – will participate in M+C plans. CRS Report at 8. However, beneficiaries' access to M+C plans will depend upon the willingness of private health plans to offer services under the program.[5]

B. Congress Has Granted Medicare Beneficiaries Expansive Rights To Appeal The Denial Of Treatment By Organizations Providing Medicare Coverage.

A beneficiary's right to appeal a denial of benefits has long been a key feature of Medicare's risk-contract program

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[4] The 1997 amendments to the Medicare Act provided that HCFA may not enter into or renew a contract with a risk-based HMO under the former statutory authority after the rules for M+C contractors come into effect. See 42 U.S.C. § 1395mm(k). Thus, all Medicare HMOs that have remained in the program have become M+C organizations.

[5] In September 2000, about 72% of the 39 million Medicare beneficiaries had access to one or more of the 260 participating M+C plans. CRS Report at 4.

and continues to be central under the Medicare+Choice program. In the traditional fee-for-service program, most appeals are filed by physicians and suppliers, rather than beneficiaries, and concern the denial of payment *after* care has been rendered. See Testimony of Michael Hash, Deputy Administrator, HCFA, before the Subcommittee on Health of the House Committee on Ways and Means (April 22, 1999) ("Hash Testimony") <http://www.hcfa.gov/testmony/1999/-medcov1.htm.> In contrast, when beneficiaries are enrolled in Medicare HMOs, denials generally *precede* the delivery of care, and appeals are brought by beneficiaries who are seeking medical services. *Id.* at 3-4. See Testimony of Carol Cronin, Director, Center for Beneficiary Services, HCFA, before the Senate Special Committee on Aging (April 13, 1999) ("Cronin Testimony") <http://www.hcfa.gov/testmony/-1999/appeal1.htm>. Moreover, while coverage determinations in the fee-for-service arena are made initially by the government or its fiscal intermediary (see *Heckler* v. *Ringer*, 466 U.S. 602, 606 (1984)), coverage determinations in Medicare's managed care program are made in the first instance by the participating health plan.

The government has recognized that the appeals process plays a crucial role in assuring beneficiaries "that managed care incentives to reduce unnecessary care will not be allowed to limit appropriate care." Cronin Testimony, at 5. See K. Pippin, *Increasing Consumer Power in the Grievance and Appeal Process for Medicare HMO Enrollees*, 33 U. MICH. J. L. REF. 133, 134 (1999 and 2000). Beneficiaries in the M+C program thus have been provided with extensive rights to appeal adverse decisions regarding their requests for service, and these rights have been enhanced repeatedly over the last several years. See generally J. Gladieux, *Medicare+Choice Appeal Procedures: Reconciling Due Process Rights and Cost Containment*, 25 AM. J. L. & MED. 61, 75-81, 86-90 (1999) (describing recent changes to administrative appeal process).

Indeed, although the Medicare managed care appeal process has been criticized, beneficiaries are afforded more extensive appeal rights than have been available in the private sector. In 1998, a member of the AARP Board of Directors testifying before Congress gave the Medicare managed care appeal process "high marks," stating: "Compared to what is available in private sector managed care, the Medicare appeal process remains the gold standard, despite its shortcomings." Statement of Jim Parkel, Member AARP Board of Directors, before the Subcommittee on Health of the House Committee on Ways and Means (April 23, 1998) <http://www.aarp.org/wwstand/testimony/1998/testparkel.html>.

A review of the rules bears this out. Under current regulations,[6] each M+C organization must have a procedure for making timely decisions on a request for benefits. 42 C.F.R. § 422.566(a). The organization must notify the enrollee of its decision within 14 days after a request is made. *Id.* § 422.568(a). If the organization decides to deny service in whole or in part, it must provide the enrollee with written notice of the denial, which must set forth the process for appealing the adverse determination. *Id.* § 422.570(d). An enrollee has 60 days within which to request reconsideration of an adverse determination. *Id.* §§ 422.578, 422.582(b). The organization must respond to a request for reconsideration within 30 days, or sooner if the beneficiary's condition requires it. *Id.* § 422.590.

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[6] The appeal procedures for M+C organizations, which implement Section 1852(g) of the Medicare Act (42 U.S.C. § 1395w-22) and became effective on June 27, 1998, appear at 42 C.F.R Part 422, Subpart M. These regulations have superseded the regulations applicable to risk-based Medicare HMOs that contracted with HCFA before the creation of the M&C Program, which remain codified at 42 C.F.R Part 417. See 63 Fed. Reg. 34968, 34969 (June 26, 1998).

M+C organizations also must provide expedited review procedures for situations in which delay "could seriously jeopardize the enrollee's life, health, or ability to regain maximum function." *Id.* § 422.566(a). In such cases, the organization must make its initial determination within 72 hours, and must respond to a request for reconsideration of an adverse determination within 72 hours. *Id.* §§ 422.572(a), 422.590(d)(1). That time frame is abbreviated if the patient's condition demands it. *Ibid.*

When an M+C organization affirms its adverse determination in whole or in part, it must forward the case to an independent, outside review entity for a final reconsidered determination. *Id.* § 422.592(a). HCFA contracts with the Center for Health Dispute Resolution (CHDR) to perform this function. CHDR must act on expedited appeals within 72 hours and must act on all other appeals within 14 days. *Id.* § 422.592(b); Hash Testimony, at 4.

If the amount in controversy is $100 or more, a beneficiary (but not the M+C organization) may appeal the independent review contractor's decision to a Social Security Administration Administrative Law Judge (ALJ). 42 C.F.R. §§ 422.600(a), 422.602(a). Any party dissatisfied with the ALJ's decision may appeal to the Health and Human Services Departmental Appeals Board. *Id.* § 422.608. In cases involving at least $1,000, either party may seek judicial review of the decision in federal district court, as provided in 42 U.S.C. § 405(g). See *id.* § 1395w-22(g); 42 C.F.R. § 422.612. The rights of M+C enrollees to appeal an adverse decision to federal district court are identical in substance to the rights afforded to beneficiaries enrolled in HMOs with which HCFA contracted under prior law. Compare 42 U.S.C. § 1395w-22(g) with *id.* § 1395mm(c)(5)(B) (both of which grant "judicial review of the Secretary's decision as provided in Section 205(g)" of the Medicare Act, 42 U.S.C. § 405(g)).

Beneficiaries who invoke the administrative appeal process often obtain the medical services they seek. In a July 1998 survey conducted by the General Accounting Office (GAO), Medicare HMOs reported that, between January 1996 and May 1998, they reversed their initial denials in approximately 75% of cases presented to them for reconsideration. GAO, MEDICARE MANAGED CARE: GREATER OVERSIGHT NEEDED TO PROTECT BENEFICIARY RIGHTS (April 1999) ("GAO Report") at 2. Denials that were not overturned were forwarded to CHDR for further review. *Id.* at 12. In 1999, CHDR decided 17% of the cases that it reviewed in favor of the beneficiary and affirmed the HMO's decision in 67% of cases; another 12% of cases were withdrawn, 2% were partially reversed and, in 1% of cases, beneficiaries were permitted retroactively to disenroll from the managed care program and switch to fee for service. CHDR, Medicare Managed Care Reconsideration Data (2/1/2001) ("CHDR Data"), at Table 1.

As participation in Medicare managed care plans has expanded, the number of cases reviewed also has increased. In 1997, 9,024 appeals were sent to CHDR. Statement of Michael Hash, Deputy Administrator, HCFA, before Subcommittee on Health of the House Committee on Ways and Means (April 23, 1998) ("Hash Statement") <http://www.-hcfa.gov/testmony/1998/98_0423.htm. That number increased to 14,745 cases in 1998, and 20,403 cases in 1999. See Cronin Testimony, at 5; CHDR Data, at Table 1.[7]

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[7] The appeal process is likely to become even more important in the future, as new limits on Medicare beneficiaries' ability to disenroll from managed care plans become effective. Currently, a Medicare beneficiary enrolled in a managed care plan may disenroll at the end of any month and elect traditional fee-for-service coverage. 42 C.F.R. § 406.21(f); see also *id.* §§ 407.12-.15. Beginning on January 2, 2002, however, Medicare beneficiaries will be able to change their health plan only during an annual "open

C. The Decision Below, Which Permits Beneficiaries To Sidestep The Administrative Process For Appealing The Denial Of Medical Services In Favor Of Bringing A Tort Action, Is A Significant Threat To The Medicare+Choice Program.

Based on its mistaken conclusion that this lawsuit was not "inextricably intertwined with a claim for Medicare benefits" (Pet. App. 16a), the California Supreme Court allowed a Medicare enrollee who had not appealed his HMO's alleged denial of service to pursue state tort claims seeking damages allegedly resulting from the denial. Under that ruling – which now governs the 24% of Medicare+Choice enrollees who reside in California and will create uncertainty as to the rights of enrollees in other jurisdictions – a Medicare beneficiary may simply sidestep the process that Congress and the Secretary of Health and Human Services created to resolve coverage disputes between Medicare HMOs and beneficiaries quickly, fairly and cost-effectively. "If litigants who have been denied benefits could routinely obtain judicial review of these decisions by recharacterizing their claims under state * * * causes of action, the Medicare Act's goal of limited judicial review for a substantial number of claims would be severely undermined." *Bodimetric Health Servs., Inc.* v. *Aetna Life & Cas.*, 903 F.2d 480, 487 (7th Cir. 1990). Such substantial interference with a federal program should not be permitted at all; at the very least, any decision to expand collateral state-court litigation over core determinations made within one of the largest federal programs merits this Court's immediate consideration.

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season." See *id.* § 422.62(a)(4). Because beneficiaries who are aggrieved by a coverage decision by a M+C organization no longer will be able to withdraw from the plan and go the fee-for-service route, the number of appeals from denials of benefits can be expected to increase.

1. Allowing beneficiaries who have not invoked the administrative process to seek damages predicated on the refusal of benefits will be of little help to beneficiaries, but will impose substantial and unwarranted new costs on the Medicare system.

As discussed above, participants in Medicare managed care plans have extensive rights to appeal the denial of coverage for medical services. Seeking administrative review of a denial of benefits is a quick and effective way for a beneficiary to obtain medical treatment that he or she feels has been wrongfully withheld. As noted, Medicare HMOs themselves grant nearly 75% of requests for reconsideration that are presented to them, and those denials that are reaffirmed are automatically reviewed by an independent outside organization. The availability of expedited review ensures that a beneficiary will not risk his health by invoking his administrative remedies. Use of the administrative process reduces the chances that a beneficiary will suffer any consequential harm from an *erroneous* failure to provide benefits and minimizes the cost of determining that benefits have been *correctly* withheld.

Permitting beneficiaries who have ignored their appeal rights to sue for damages will do nothing to preserve the health of patients, but will impose enormous litigation costs on the private entities that choose to enroll Medicare beneficiaries in their health plans. Medicare HMOs make thousands and thousands of coverage decisions each year, and they must deny requests for treatment that are not covered by Medicare or otherwise covered by the plan. If even a tiny fraction of the claims denied result in tort litigation, then the cost to a private entity of participating in the Medicare program will skyrocket. These costs can be avoided, without harm to patients, if all claims are channeled to the administrative appeal process.

This case exemplifies the point. As the transcript of his deposition makes clear,[8] respondent McCall never even gave his HMO the chance to consider providing him with the benefits he claimed he needed. According to McCall, his treating physician advised him that PacifiCare would require him to undergo a lung transplant at UCLA or Cedars-Sinai, but would not cover a lung transplant at the University of California at San Diego, where McCall wished to have the procedure. Petitioner's Lodging, at 13-14. When given this news, McCall immediately disenrolled from PacifiCare and enrolled in the traditional fee-for-service program, which did not restrict his choice of hospitals. *Id.* at 14-15, 21. Contending that PacifiCare had "chose[n its] well-being over [his]" (*id.* at 12), McCall sought to recover as damages the additional out-of-pocket costs he incurred after he disenrolled from PacifiCare to obtain medical services that would have been covered by his HMO but were not covered by the fee-for-service program. *Id.* at 24.

Both McCall and PacifiCare would have been far better off had McCall taken advantage of the administrative process to appeal the denial of benefits. If it was indeed improper for PacifiCare to direct McCall to UCLA or Cedars-Sinai rather than UCSD for his lung transplant, then a request for reconsideration to PacifiCare itself and, if necessary, to an independent review body, might well have been fruitful. If it had been, McCall would have received the treatment he desired and would not have suffered the inconvenience and expense of returning to the fee-for-service program. If, instead, PacifiCare was justified in requiring McCall to seek treat-

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[8] Although the courts below did not consider them, the facts disclosed in Mr. McCall's deposition are relevant here because they demonstrate the importance of channeling disputes concerning the provision of medical services to the administrative appeal process. Petitioners have lodged a copy of the relevant deposition transcript with the Clerk of the Court.

ment within its network, then McCall would promptly have received a ruling to that effect and avoided protracted litigation. Instead, years have passed since McCall filed his complaint (and McCall himself has died), yet the California courts are still a long way from deciding whether PacifiCare's denial of benefits was appropriate.

The costs imposed by allowing other Medicare beneficiaries to take their grievances to the courts under these circumstances will dramatically affect the future prospects of the Medicare+Choice program. As noted above, the program's success depends on the willingness of a variety of health plans to enter into contracts with HCFA to serve Medicare beneficiaries. In light of the program's administrative burdens and slim profit margins, securing the participation of health plans has at times been difficult. See J. Gladieux, *supra*, 25 AM. J. L. & MED. at 102; CRS Report, at 4. Allowing more Medicare beneficiaries to sue their HMOs – or merely creating uncertainty about whether or not they will be able to do so – may tip the balance against participation for many organizations. This will reduce the health care options available to senior citizens and individuals with disabilities.

2. The California Supreme Court's decision also will reduce consistency in benefit determinations. Requiring aggrieved beneficiaries to employ the administrative process fosters uniform treatment of claims that benefits have been wrongly denied. As noted above, HCFA now contracts with a single independent contractor to review *all* instances in which an HMO or other M+C organization denies reconsideration of a claim for benefits. Similarly, the ALJs who provide further review of denials of treatment – like the members of the Appeals Board that reviews ALJ decisions – review scores of Medicare treatment decisions. Although there is no guarantee that similar cases will fare identically in the administrative process, the system is designed to maximize the chances that cases will be resolved consistently. See

Shalala v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 13 (2000) ("'channelling' * * * virtually all legal attacks through the agency * * * assures the agency greater opportunity to apply, interpret, or revise policies, regulations, or statutes without possibly premature interference by different individual courts"). Such consistency is fair to beneficiaries and provides M+C organizations with clear guidance for deciding future requests for benefits.

In contrast, the approach sanctioned by the California Supreme Court is a recipe for havoc. As the dissenting justices below observed, "plaintiffs' ability to prevail on their state law causes of action inevitably turns upon a determination that plaintiff George McCall was entitled to a Medicare benefit * * * and that PacifiCare had no right to deny such benefit because it was reasonable and necessary for treatment of his condition." Pet. App. 31a. Allowing state courts to rule on the propriety of benefit determinations in the course of adjudicating a Medicare HMO's tort liability will result in inconsistent decision-making. Because they lack standards for evaluating benefit determinations, judges and juries inevitably will resolve similar cases differently from one another and from the experts deciding the same issues within the administrative framework. If states other than California begin to entertain tort suits based on the coverage decisions of Medicare HMOs, the divergence among cases will increase, and beneficiaries will be encouraged to engage in forum-shopping.

This inconsistency will be unfair to beneficiaries, as it may encourage HMOs to vary their benefit determinations according to where the beneficiary resides. Allowing the state tort system to operate alongside the administrative process also will make it more difficult for Medicare HMOs to discern what rules they should follow in particular cases.

Indeed, if benefits decisions are exposed to the vagaries of the tort system, M+C organizations may decide to grant

even the most marginal requests for service, thereby increasing the costs of coverage and defeating the salutary purposes of managed care. Alternatively, they may simply withdraw from the Medicare program. Cf. *Midland Psychiatric Assocs., Inc.* v. *United States*, 145 F.3d 1000, 1005 (8th Cir. 1998) ("insurers * * * might well rethink their contracts with the Government if they had to make Medicare claims decisions under the threat of tort liability"). This would defeat the goals of the Medicare+Choice program, by depriving beneficiaries of the option of participating in health care plans that may suit their needs better than traditional fee-for-service coverage.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

KENNETH S. GELLER
Counsel of Record
MIRIAM R. NEMETZ
Mayer, Brown & Platt
1909 K Street, N.W.
Washington, D.C. 20006
(202) 263-3000

LOUIS SACCOCCIO
General Counsel
American Association of Health Plans
1129 20th Street, N.W.
Suite 600
Washington, D.C. 20036
(202) 778-3200

LYNN D. DUDLEY
Vice President and Senior Counsel
American Benefits Council
1212 New York Avenue, N.W.
Suite 1250
Washington, D.C. 20005
(202) 289-6700

JEFFREY L. GABARDI
Legislative Director and Deputy General Counsel
Health Insurance Association of America
1201 F Street, N.W.
Suite 500
Washington, D.C. 20004
(202) 824-1621

Counsel for *Amici Curiae*

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